The Commonwealth of Massachusetts
Health Policy Commission
Office of Patient Protection
Two Boylston Street
Boston, MA 02116
800-436-7757- Phone
617-624-5046 – Fax

REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A HEALTH INSURANCE GRIEVANCE

If your health insurance company will not pay for treatment that you believe you need, you may be able to ask an outside medical expert to review your insurance company's decision. This is called an external review. If a patient's medical condition is urgent, you can request an expedited external review.

- **For a regular external review, you must first file a grievance with your insurance company, asking for an internal review of the decision. If after the internal review the answer is still no, you can request an external review within four months of receiving a «final adverse determination» from your insurance company. A final adverse determination is the written notice from your health insurer telling you that your claim is being denied based on medical necessity, appropriateness of health care setting and level of care, or effectiveness of treatment, and that you have exhausted the insurer's internal appeals process.**

- **For an expedited external review, you must request an external review within two days of your insurance company's decision to deny coverage for your treatment. You may choose to file a request for an expedited external review at the same time that you request an expedited internal review from your insurance company. If you file the request for an expedited internal review and expedited external review at the same time, you do not need a final adverse determination.**

A patient may request an expedited external review in the event of a serious and immediate threat to the patient's health. A request for an expedited external review must contain a certification, on the enclosed form or in writing, from your physician or primary care provider that delay in the provision or continuation of health care services would pose a serious and immediate threat to the health of the patient. If you are requesting an expedited review, please complete the entire application.

In an expedited review, you may:

- request that your insurance company continue to pay for your treatment while the external review is being decided;
- request an expedited internal review by your insurer at the same time that you request an expedited external review; and
- receive a decision within four days of filing your request for external review

YOUR REQUEST FOR EXTERNAL REVIEW
WHAT TO SEND AND WHERE TO SEND IT

Please be sure your request includes **all** of the following:

- ☐ This completed application form.
- ☐ A check or money order for $25 made out to the Commonwealth of Massachusetts (unless you ask OPP to waive the fee on page 8).
- ☐ A copy of the final adverse determination or denial letter from your health insurer (not necessary if you are filing a request for expedited external review at the same time that you are filing a request for expedited internal review with the insurer).
- ☐ A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in this application.
- ☐ Any medical records, statements from your treating health care providers, or other information that you would like the independent review agency to consider in reviewing your case (the independent review agency will request records of the treatment that is the subject of the adverse determination).

If you need assistance in completing this form, or do not have one or more of the above items and would like information on alternative ways to complete your request, please call the Office of Patient Protection at 800-436-7757.

Fax the External Review request materials to 617-624-5046 or mail to:

Office of Patient Protection
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

Applications requesting an expedited review should be faxed to the Office of Patient Protection at 617-624-5046. After faxing your expedited external review request, please call 800-436-7757 to advise the Office of Patient Protection that a request has been faxed.

PATIENT INFORMATION

1. Patient's Name:	
2. Mailing Address:	
3. Daytime Phone:	

INFORMATION ABOUT THE PATIENT'S HEALTH INSURANCE COVERAGE

4. Policyholder's Name:	
5. Patient's Insurance ID Number:	
6. Name of Health Insurance Company:	
7. Person at Health Insurance Company Involved with Your Appeal (if known):	

8. Describe the disagreement with your health plan and, if possible, indicate the services for which coverage was denied. Attach additional pages if needed. Please attach the adverse determination, any other information you received from your health plan concerning the denial, and any additional information from your health care provider that you want the external reviewer to consider.

INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER

Name of health care provider who ordered the service which was not covered:

_____

Type of Provider: ☐ Physician ☐ Other (please specify):_____

Provider Mailing Address:

_____

_____

Provider Phone Number: _____

INFORMATION ABOUT YOUR HEALTH HISTORY

If you want the external review agency to consider records of your previous treatment, please list the provider(s) and dates here. Attach additional sheets if needed.

Provider Name: _____

Provider Mailing Address:

_____

_____

Provider Phone Number: _____

Dates of treatment: _____

<u>Fill out this section only if someone else will be representing you in this review.</u>

You can represent yourself, or may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization in writing at any time.

9. I hereby authorize _____ to pursue my external review on my behalf.

_____ _____

Signature of Patient (or Legal Representative)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify): _____

Address of Authorized Representative:

_____

_____

_____

Phone Number: Daytime: _____ Evening: _____

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REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

The Office of Patient Protection (OPP) will randomly assign your case to one of the three agencies with which it has contracts for external review: Medical Consultants Network (MCN), the Island Peer Review Organization (IPRO) or Independent Medical Expert Consulting Services, Inc. (IMEDECS). This form will authorize the release of medical records to the agency that will conduct the review. This authorization may be revoked at any time by writing to the Office of Patient Protection at the address on page one, but information previously released in reliance upon the authorization will not be affected by the revocation.

I, _____, hereby request an external review of the matter described on page 3 of this application. I attest that the information provided in this application is true and accurate to the best of my knowledge.

I authorize my HMO, health insurer or health care providers to release all relevant medical or treatment records related to the matter described in this request for external review to the external review agency named by the Office of Patient Protection to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

According to 958 CMR 3.416, no external review agency or reviewer shall, except as specifically authorized by an appropriate release signed by a patient or representative authorized by law, release medical and treatment information or other information obtained as part of an external review, except to the Office of Patient Protection and as otherwise authorized or required by law. I understand that the external agency may not be covered by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the state Fair Information Practices Act.

I understand that the Office of Patient Protection may not be covered by federal privacy laws, and that the Office of Patient Protection may be able to further share the information that is given to it. Note, however, that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)), and that the Office of Patient Protection will not share your medical records with anyone without your written permission or unless otherwise required by law.

_____ _____
Signature of Patient (or Legal Representative)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify) :_____

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records.

Permission about Specific Health Information

Please write your initials and sign below to authorize the release of any of the following information:

_____I specifically give permission, as required by M.G.L. c. 111, § 70F, to release information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment, to the external review agency.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to release information in my record about my genetic information to the external review agency.

____I specifically give permission to release information in my record about alcohol or drug treatment to the external review agency. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the re-disclosure of this confidential information.

_____ _____

Signature of Patient (or Legal Representative)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify):_____

AUTHORIZATION TO REFER CASE TO ANOTHER STATE AGENCY

The Office of Patient Protection may wish to refer this case, including medical records released by this authorization, to the Massachusetts Division of Insurance or the Office of the Attorney General for further investigation and possible action against the insurer.

I understand that other state agencies may not be covered by federal privacy laws, and that they may be able to further share the information that is given to them. (Note, however, that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c).)

Please check one of the following:

☐ I give my permission to the Office of Patient Protection to refer my case to the Division of Insurance, the Office of the Attorney General or another relevant state agency.

☐ I do not give my permission to the Office of Patient Protection to refer my case to another state agency.

☐ Please call me to discuss the referral of my case to another state agency. I understand that you will need my written permission to share medical information.

_____ _____

Signature of Patient (or Legal Representative)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify)

_____

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Complete this form only if you are requesting review of a claim for mental health services.

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF PSYCHOTHERAPY NOTES

The Office of Patient Protection (OPP) will assign your case to one of the three external review agencies: Medical Consultants Network (MCN), the Island Peer Review Organization (IPRO) or Independent Medical Expert Consulting Services, Inc. (IMEDECS). This form will authorize the release of psychotherapy notes to the agency that conducts the review. This authorization may be revoked at any time by writing to OPP at the address on page one, but information previously released in reliance upon the authorization will not be affected by the revocation.

I _____, hereby request an external review of the matter described on page 3 of this application.

I authorize my HMO, health insurer or health care providers to release all relevant psychotherapy notes related to the matter described in this request for external review to the external review agency named by the Office of Patient Protection to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

I understand that the external review agency may not be covered by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the state Fair Information Practices Act. Note that according to 958 CMR 3.416, no external review agency or reviewer shall, except as specifically authorized by an appropriate release signed by a patient or representative authorized by law, release medical and treatment information or other information obtained as part of an external review, except to the Office of Patient Protection and as otherwise authorized or required by law.

I understand that the Office of Patient Protection may not be covered by federal privacy laws, and that the Office of Patient Protection may be able to further share the information that is given to it. (Note that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)), and that the Office of Patient Protection will not share your records with anyone without your written permission or unless otherwise required by law.

_____ Date:_____
Signature of Patient (or Legal Representative)*

*(Parent, Guardian, Conservator, or Other – Please Specify) : _____

EXTERNAL REVIEW FEE AND FEE WAIVER

The patient seeking an external review is responsible for the first $25 of the cost of the review. The insurance company pays the remainder.

You must enclose a check or money order for $25 made out to the Commonwealth of Massachusetts, or request a waiver of this fee.

☐ I have enclosed the check or money order for $25.

☐ I am requesting that the Office of Patient Protection waive the $25 fee because the payment of the fee would result in extreme financial hardship for me. Check one of the boxes below:

☐ I have Commonwealth Care insurance.

☐ My income is less than or equal to 300% of the federal poverty level (FPL), according to the chart below

2013 Guidelines – 300% FPL

Persons in Family	**Yearly Income**
1	$34,476
2	46,536
3	58,596
4	70,656
5	82,716
6	94,776
7	106,836
8	118,896
For each additional person, add	12,060

☐ My income exceeds the guidelines but payment of the $25 would cause me extreme financial hardship because:

_____

_____

_____

Please note that you must demonstrate financial hardship in order for OPP to waive the $25 fee.

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The Office of Patient Protection will screen your request to verify that all information is complete, that your request relates to a final adverse determination from a health insurer (unless you are filing a request for expedited external review at the same time that you are filing a request for expedited internal review to the health plan), and that the requested service is not specifically excluded from coverage in your health plan evidence of coverage. If your case is eligible, it will be sent to one of the external review agencies under contract with the Health Policy Commission. The external review agency must complete its review within four business days for expedited requests and 60 calendar days for all other requests. If you have any questions about the review process, please call the Office of Patient Protection at 800-436-7757.

If you are requesting an expedited review, please complete the entire application (pages 1-12).

REQUESTS FOR EXPEDITED REVIEW

A patient may request an expedited external review in the event of a serious and immediate threat to the patient's health. A request for an expedited external review must contain a certification, in writing, from your physician or primary care provider that delay in the provision or continuation of health care services would pose a serious and immediate threat to the health of the patient. If you are requesting an expedited review, please complete the entire application (pages 1-12).

If this is a request for an Expedited Review, a physician or primary care provider must complete pages 11 and 12, labeled "Certification for Expedited External Review." You must provide the form to your physician or primary care provider, and the physician or primary care provider must fax the completed form to the Office of Patient Protection.

I sent the form to my physician or primary care provider. Please check one:

☐ By Mail ☐ By Fax ☐ Other (describe) _____

☐ I did not send the form to the physician/primary care provider. (Please explain):

Name of Provider:	
Address:	
Phone:	

REQUEST TO HAVE COVERAGE CONTINUE DURING THE EXTERNAL REVIEW

If the subject matter of the external review involves the termination of ongoing services, the patient may apply to the external review agency to seek continued insurance coverage for the terminated service during the period the review is pending. Any such request must be made **before the end of the second business day** following receipt of the final adverse determination from the insurer (final adverse decision not required if you are filing a request for expedited external review at the same time that you are filing a request for expedited internal review to the health plan). The review agency may order the continuation of coverage or treatment where it determines that substantial harm to the patient's health may result if the coverage or treatment is not continued or for other good cause as the review agency determines. Any such continuation of coverage will be at the insurer's expense regardless of the final external review determination.

☐ I am requesting continuation of services that were previously authorized by the insurer.

_____ _____

Signature of Patient or Authorized Representative Date

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CERTIFICATION FOR EXPEDITED EXTERNAL REVIEW

A patient or the patient's authorized representative, if any, may request an expedited external review if the physician or primary care provider who ordered the services certifies that delay in the provision or continuation of health care services that are the subject of an adverse determination would pose a serious and immediate threat to the health of the patient.

The physician or primary care provider must complete this certificate and immediately fax it to the Office of Patient Protection at 617-624-5046 in order for a patient to be eligible for an expedited external review of a medical necessity determination. **The patient must complete pages 1-10 as well. OPP cannot consider any request for external review until the entire application is received.**

Name of Patient: _____

Patient's Phone Number: _____

Patient's Health Plan Member ID Number: _____

Name of Physician/Primary Care Provider completing this form:

_____

Address: _____
_____
_____

Contact Person: _____

Phone Number: _____
Fax Number: _____

An expedited decision is necessary because a delay in providing the recommended health service would pose a serious and immediate threat to the health of the patient.

_____ YES _____ NO

Continued on next page

If yes, explain the nature of the serious and immediate threat to the health of the patient (attach additional documents if needed):

_____

_____

_____

_____

_____

_____

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____
Physician/Primary Care Provider's Name

_____
Signature

_____
Date

Physician/Primary Care Provider's Office Stamp:

Fax this completed certificate to 617-624-5046. Pages 1-10 can be faxed with this certificate or may be sent separately but the request cannot be processed without a complete application.

If you have any questions, please call the Office of Patient Protection at 800-436-7757.